Massachusetts Division of Health Care Finance and Policy

Uncompensated Care Pool

Community Health Centers Electronic Claims Submission Requirements

Final Version

11/4/2002

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Input Record Layouts and Specifications

Data Elements

The logical Claim is made up of a series of 128 character records. Standard COBOL documentation is used for record descriptions. The following definitions are given to ensure consistency of interpretation:

The Record Type Specifications that follow provide the following data for each field in the record:

Data Element	Definition
FIELD NO.	Field Number: Sequential number for the field in the record.
FIELD NAME	Field Name: The short definition, name, or literal constant of the data located within the record at the positions indicated.
PICTURE	Picture: The COBOL "PICTURE" clause that describes how the data is presented on the tape/diskette. X = an alphanumeric character 9 = a numeric character S = the field is signed (+ or -) V = an implied decimal point ( ) = the character in front of the left parenthesis is repeated the number of times between the parentheses, e.g., X(05) represents the same PICTURE as XXXXX.
BYT.	Bytes: The length of the field expressed in physical characters.
TP.	Field Type: Format required for field. Refer to **Field Types** section below. The type of data in the field. A -Alphanumeric N - Numeric
FROM POS.	From Position: Leftmost position of the field in the 128 character record. The beginning physical character position of the field.
TO POS.	To Position: Rightmost position of the field in the 128 character record. The last physical character position of the field.
R?	Field Requirement Indicator. R = Required, N = Not Required, C = Conditionally Required. Refer to Edit Specifications data (below) for details about requirements.
Edits	Edit Specifications: Defines the criteria that will cause the field to pass or fail. Explanation of Conditional Requirements. List of edits to be performed on fields to test for validity of File, Batch, and Claim.

Data Element	Definition
Field Definition	Definition of the field name and/or description of the expected contents of the field.

Field Types

Field Type	Field Use	Cobol Picture Example	Definition	Field Examples
A (Alphanumeric)	Text field	X(21)	Alpha-numeric characters (A-Z and 0-9) left-justified with trailing spaces.	a) Submitter's Name (a 20 chara field) might be entered as: Village Health (followed by 6 spaces).
N (Numeric)	Date field	9(06)	Date fields are 6 characters. The field is formatted as follows: MMDDYY	February 14, 2000 would be ente 021400 NOTE: Blank date fields must be expressed with spaces; filling a field with zeros will result in an er
	Numeric field	9(06)	Numeric, whole, unsigned, integer digits, right-justified. **NOTE:** Decimal places may be included for Units of Service ONLY (K11).	Batch Total Claim Lines (a 6 cha field) might be entered as: 229 OR 000229 (preceded by 3 spaces, or 3 zerc Units of Service (a 4 character fie might be entered as: .5 OR 00.5 (preceded by 2 spaces, or 2 zerc
	Numeric field which contains a currency amount	9(06)V99 Also described as: $$$$$$cc	(Unformatted) numeric, whole, unsigned, integer digits, right-justified. Last two digits will indicate cents. Always include cents, but no decimal.	20 dollars in a 8 character field w entered as: 2000 OR 00002000 (preceded by 4 spaces, or 4 zerc

Data Sequence and Descriptions

Six different records must appear on the CHC Uncompensated Care Pool Claims Submission File:

Record ID	Record Name	Definition	Requirements
G	Submitter Header	Identifies who submitted the file.	One record per file
H	Provider Batch Header	Identifies the billing provider.	One record per file
J	Claim Detail-1	Specifies Recipient and Claim Information. (Also known as the Claim Header.)	One record per claim
K	Claim Detail-2	Specifies actual services rendered and amounts billed. Claim Detail records must add up to the amount on the Claim Header	At least one record per claim
L	Provider Batch Trailer	Specifies totals for the corresponding batch header for a particular provider.	One record per file
M	Processor Trailer	Contains totaling information for entire file.	One record per file

Input Record Specifications

RECORD (G): SUBMITTER HEADER

- Encode one per submission.
- Must be the first record in the file.

RECORD (G): SUBMITTER HEADER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
1	RECORD ID 'G'	X(01)	1	A	1	1	R	Must be present. Must be G.	A one-character code that identifies the type of Record.
2	FILLER (SPACES)	X(02)	2	A	2	3	N		
3	SUBMITTER NUMBER (BILLING AGENT NO.)	9(07)	7	N	4	10	N		
4	FILLER (SPACES)	X(06)	6	A	11	16	N		
5	SUBMITTER'S NAME	X(20)	20	A	17	36	R	Must be present.	The name of the company who created this submission
6	SUBMITTER'S ADDRESS	X(20)	20	A	37	56	N		
7	SUBMITTER'S CITY	X(18)	18	A	57	74	N		
8	SUBMITTER'S STATE	X(02)	2	A	75	76	N		
9	SUBMITTER'S ZIP CODE	9(05)	5	N	77	81	N		
10	SUBMITTER'S TEL. NUMBER	9(10)	10	N	82	91	N		
11	FILLER (SPACES)	X(37)	37	A	92	128	N		

RECORD (H): PROVIDER BATCH HEADER

- Encode one per provider batch.
- Must be preceded by a (G) record.
- Must be followed by a (J) record.

RECORD (H): PROVIDER BATCH HEADER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
1	RECORD ID 'H'	X(01)	1	A	1	1	R	Must be present. Must be H.	A one-character code that identifies the type of Record.
2	**UNCOMPENSATED CARE POOL ORGANIZATION ID FOR PROVIDER**	**9(07)**	**7**	**N**	**2**	**8**	**R**	**Must be present.** **Must be valid entry as specified in Code Lists. (Section (I))** **Must match the Organization ID on the Transmittal Sheet.**	**The Organization ID assigned to the provider by the Massachusetts Division of Health Care Finance and Policy.**
3	PROVIDER'S NAME	X(20)	20	A	9	28	R	Must be present.	The name of the Provider (CHC) submitting this batch of claims.
4	PROVIDER'S ADDRESS	X(20)	20	A	29	48	R	Must be present.	The Legal Entity Mailing Address (street number and name or post office box number) of Billing Provider.
5	PROVIDER'S CITY	X(18)	18	A	49	66	R	Must be present.	The Legal Entity City of the Billing Provider.
6	PROVIDER'S STATE	X(02)	2	A	67	68	R	Must be present.	The two-character U. S. Postal Service abbreviation of the State of the Billing Provider.
7	PROVIDER'S ZIP CODE	9(05)	5	N	69	73	R	Must be present.	The U. S. Postal Service five-digit ZIP Code of the Billing Provider.

RECORD (H): PROVIDER BATCH HEADER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
8	**BILLING DATE (MMDDYY)**	**9(06)**	**6**	**N**	**74**	**79**	**R**	**Must be present.** **Must not be later than date received.**	**The Date in MMDDYY format the Provider or Provider Group is billing the Uncompensated Care Pool for these claims by electronic file.**
9	**FILLER (SPACES)**	**X(49)**	**49**	**A**	**80**	**128**	**N**		

RECORD (J): CLAIM DETAIL-1

- This is the Claim Header.
- Encode one per invoice.
- Must be preceded by the (H) record or a (K) record.
- Must be followed by a (K) record.

RECORD (J): CLAIM DETAIL-1									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
1	RECORD I.D. 'J'	X(01)	1	A	1	1	R	Must be present. Must be J.	A one-character code that identifies the type of Record.
2	PRIOR AUTHORIZATION NUMBER	X(06)	6	A	2	7	N		
3	FILLER (SPACES)	X(04)	4	A	8	11	N		
4	PAY TO PROVIDER NO.	X(07)	7	A	12	18	N		
5	**SERVICING PROVIDER NUMBER**	**X(07)**	**7**	**A**	**19**	**25**	**R**	**Must be present.** **Must be valid State License Number (Board of Registration in Medicine Number), or valid entry as specified in Code Lists section of this document. (Section (II))**	**The State License Number (Board of Registration in Medicine Number) assigned to identify the licensed physician who treated the Recipient. If caregiver is not a physician, enter type of Caregiver as listed in the Code Lists section of this document.**
6	RECIPIENT'S LAST NAME	X(12)	12	A	26	37	R	Must be present.	Patient Last Name
7	RECIPIENT'S FIRST NAME	X(12)	12	A	38	49	R	Must be present.	Patient First Name

RECORD (J): CLAIM DETAIL-1									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
8	RECIPIENT'S MIDDLE INITIAL	X(01)	1	A	50	50	C	Include if existing and available.	Patient Middle Initial
9	**RECIPIENT'S SOCIAL SECURITY NUMBER**	**X(9)**	**9**	**A**	**51**	**59**	**C**	**Include if available.** **Must be valid SSN.**	**Patient Federal Social Security Number**
10	**FILLER**	**X(1)**	**1**	**A**	**60**	**60**	**N**		
11	PATIENT ACCOUNT NUMBER	X(10)	10	A	61	70	R	Must be present.	The Patient Account Number assigned by the Provider for internal use. If the Provider does not assign Patient Account Numbers, enter the Recipient's Last Name.
12	**PLACE OF SERVICE**	**9(02)**	**2**	**N**	**71**	**72**	**C**	**Include if available.** **Must be valid code as specified in Code Lists section of this document. (Section (III))**	**A two-digit code that identifies where the service being billed was rendered.**
13	ACCIDENT INDICATOR	X(01)	1	A	73	73	C	Include if applicable.	Enter 'X' if the treatment being provided is the result of an accident.
14	SCREENING PGH INDICATOR	X(01)	1	A	74	74	C	Include if applicable.	Enter 'X' if the Services provided are the result of an EPSDT/PGH Screening referral or related to a PGH assessment.
15	REFERRING PROVIDER NUMBER	9(07)	7	N	75	81	N		
16	**OTHER INSURANCE CODE – PAYER TYPE**	**X(01)**	**1**	**A**	**82**	**82**	**C**	**Include if applicable.** **Must be valid entry as specified in Code Lists. (Section (IV))**	**Include if Recipient has insurance other than the Uncompensated Care Pool (Free Care), otherwise space fill.**

RECORD (J): CLAIM DETAIL-1									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
17	ICD-9-CM PRIMARY DIAGNOSIS CODE	X(05)	5	A	83	87	R	Must be present, unless ALL procedure codes in K records for the claim are Optometry, Dentistry, or Podiatry, in which case this field is not required or may be V65. If present, must be a valid ICD-9-CM code for the time period of the From Date of Service	The three to five-character International Classification of Diseases 9th Revision (Clinical Modification) Code that describes the Patient's Primary medical problem requiring treatment. The code is not a numeric entry. The field must be left-justified with trailing space(s). The code must appear exactly as it appears in the ICD-9-CM Code book without the decimal point delineator. If the code has a fourth or fifth digit qualifier, that fourth or fifth digit must appear on the tape/diskette.
18	ICD-9-CM SECONDARYDIAGNOSIS CODE	X(05)	5	A	88	92	C	Include if applicable. If present, must be a valid ICD-9-CM code for the time period of the Date of Service	The Code that describes the Patient's Secondary medical problem. Refer to Record J Field 17 for information concerning structure and billing requirements.
19	**TOTAL USUAL FEE**	**9(06)V99**	**8**	**N**	**93**	**100**	**R**	**Must be present.** **Must be the correct number as defined.** **Must be valid format as defined in the Field Types section of this document.**	**The sum of all the Medical Service line item charges (Usual Fee) as reflected on the Claim Detail-2 Records (Record K, field 13) encoded for this claim (following this record J and preceding the next record J if any).**
20	**RECIPIENT'S SEX**	**X(01)**	**1**	**A**	**101**	**101**	**R**	**Must be present.** **Must be valid entry as specified in Code Lists. (Section (V))**	**A Code indicating Sex of the Recipient for whom the service was rendered. (M = Male, F = Female, U = Unknown)**

RECORD (J): CLAIM DETAIL-1									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
21	RECIPIENT'S DATE OF BIRTH	9(06)	6	N	102	107	R	Must be present. Must not be later than From Date of Service (K3).	The Recipient's Date of Birth in MMDDYY format.
22	TYPE OF ACCIDENT	X(01)	1	A	108	108	C	Must be present if there is an X in Record J Field 13. Must be valid entry as specified in Code Lists. (Section (VI))	Enter 1, 2 or 3 if an Accident has been indicated with an 'X' in the Accident Indicator Field (Record J, Field 13).
23	DATE OF ACCIDENT	9(06)	6	N	109	114	C	Must be present if there is an X in Record J Field 13. Must not be later than From Date of Service (K3).	The date of the accident. MMDDYY format.
24	LEVEL OF FUNCTIONING	9(03)	3	N	115	117	N		
25	DISCHARGE DATE	9(06)	6	N	118	123	C	Include if applicable.	The date of discharge. MMDDYY format.
26	**PATIENT DISCHARGE STATUS**	**X(02)**	**2**	**A**	**124**	**125**	**C**	**Include if available.** **Must be valid entry as specified in Code Lists. (Section (VII))**	**A two-digit code to indicate the Patient Status at the time of discharge from the hospital.**
27	**CENTURY OF BIRTH**	**X(01)**	**1**	**A**	**126**	**126**	**R**	**Must be 8, 9 or 0.**	**Indicates whether the century of birth in Record (J) Field 21 was the 1800s (8), the 1900s (9) or the 2000s (0).**
28	**DEMONSTRATION PROJECT ENROLLEE**	**X(01)**	**1**	**A**	**127**	**127**	**C**	**Include if available.**	**Enter 'X' if the patient is a Demonstration Project Enrollee.**

RECORD (J): CLAIM DETAIL-1									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
29	**ORIG, RESUB, LATE CHARGES, VOID INDICATOR**	**X(01)**	**1**	**A**	**128**	**128**	**R**	**Must be present.** **Must be a valid code as specified in the Code Lists section of this document. (Section VIII).**	**Enter 'O' for Original claim, 'R' for Resubmittal claim, 'L' for Late Charges claim, or 'V' for Void claims.** **Resubmittal claims must be resubmitted in full. The Resubmittal claims must have the same TCN number and UC Writeoff date on the K record (field 15 and 16) as the Original Claim.** **Void claims must have the same TCN number as the original claim, and the UC Writeoff date on the K record (field 15 and 16) must be the month and year the recovery is made and reported on the PV form.** **Original and Late Charges claims must have new unique TCN numbers on the (K) record (field 15), and the UC Writeoff date on the (K) record (field 16) should reflect the month and year the fee is reported on the PV form.**

RECORD (K): CLAIM DETAIL-2

- Must be preceded by a (J) or a (K) record.
- Must be followed by a (K) or a (L) record.
- Encode at least one per claim.

RECORD (K) CLAIM DETAIL-2									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
1	RECORD ID 'K'	X(01)	1	A	1	1		Must be present. Must be K.	A one-character code that identifies the type of Record.
2	LINE ITEM	X(01)	1	A	2	2	N		
3	FROM DATE OF SERVICE	9(06)	6	N	3	8	R	Must be present.	The Date the Provider rendered the service. MMDDYY format.
4	TO DATE OF SERVICE	9(06)	6	N	9	14	R	Must be present. Must not be earlier than From Date of Service (K3).	The last Date the Provider Rendered the service. MMDDYY format.
5	DESCRIPTION OF SERVICE	X(16)	16	A	15	30	N		

RECORD (K) CLAIM DETAIL-2									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
6	**PROCEDURE CODE**	**X(06)**	**6**	**A**	**31**	**36**	**R**	**Must be present** **Must be a valid DMA service code as found in subchapter 6 of the relevant DMA community health center provider manual with the exception of certain X service codes which are not valid. See Code Lists section of this document for valid "X" service code replacements. (Section IX).** **Must be valid for the time period of the From Date of Service.**	**A Service Code that identifies the Service rendered.**
7	**PROCEDURE CODE MOD.**	**X(02)**	**2**	**A**	**37**	**38**	**C**	**Include if applicable.** **Must be a valid code as specified in the Code Lists section of this document. (Section X).** **Must be valid for the time period of the From Date of Service.**	**A two-digit Code that describes more fully the Service being performed.**

RECORD (K) CLAIM DETAIL-2									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
8	TREATMENT RELATED DX INDICATOR TO	X(01)	1	A	39	39	C	Include if applicable. If the Treatment Related DX Indicator To field is present, it must be a 1 or 2. In addition, if the Indicator is 1, the Primary Diagnosis Code must be present. If the Indicator is 2, the Secondary Diagnosis Code must be present.	A one digit code that indicates the relationship of the treatment to the diagnosis. **1** Relates to primary diagnosis code in Record J, Field 17 **2** Relates to secondary diagnosis code in Record J, Field 18
9	EMERGENCY SERVICE	X(01)	1	A	40	40	C	Include if applicable.	If emergency service was provided enter "X".
10	TREATMENT RELATED TO FAMILY PLANNING	X(01)	1	A	41	41	C	Include if applicable.	If the service performed is related to family planning enter "X".
11	UNITS OF SERVICE	9(04)	4	N	42	45	R	Must be present. Must be greater than zero. May contain a decimal point.	A numeric count of the number of times an identical procedure was performed on the same date of service.
12	FILLER (SPACE)	X(01)	1	A	46	46	N		
13	**USUAL FEE**	**9(06)V99**	**8**	**N**	**47**	**54**	**R**	**Must be present.** **Must be greater than zero.** **Must be a valid format as defined in the Field Types section of this document.**	**The usual and customary fee for the service being reported, in $$$$$$cc format.** **The sum of all billable Usual Fee Charges for a given claim must equal the Total Usual Fee field of the preceding Claim Header Record (J – Claim Detail-1).** **Include fees for Dental Procedures.**

RECORD (K) CLAIM DETAIL-2									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
14	**OTHER AMOUNT PAID**	**9(06)V99**	**8**	**N**	**55**	**62**	**R**	**Must be present.** **Must be a valid format as defined in the Field Types section of this document.**	**Any other amount paid for this service (other Insurance payments only).**
15	**TCN**	**X(10)**	**10**	**A**	**63**	**72**	**R**	**Must be present for the first occurrence of a (K) record for each Claim.** **Must match TCN on all Records for same Claim.** **Must be unique claim number for Provider (not to be re-used with the exception of a resubmission or cancellation of the same claim for the same patient).**	**The unique Transaction Control Number assigned by the Provider to each patient's claim that distinguishes the patient and their claim from all other claims in that institution.** **Newborns must have their own TCN separate from that of their mother.** **Resubmission or cancellation of a claim must use the same TCN as the original claim.** **Original and Late Charge claims must have a new unique TCN.**
16	**UC WRITE OFF DATE**	**9(06)**	**6**	**N**	**73**	**78**	**R**	**Must be present for the first occurrence of a (K) record for each Claim.** **Must be Year and Month Date format (CCYYMM).** **Must not be less than 200011.** **Must not be greater than the last day of the month following the date the submission is processed.**	**The month and year in which the charges on the claim are written off to the Uncompensated Care Pool on the PV Form.**

RECORD (K) CLAIM DETAIL-2									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
17	**PATIENT ZIP CODE**	**9(05)**	**5**	**N**	**79**	**83**	**R**	**Must be present for the first occurrence of a (K) record for each Claim.** **Must be valid for the time period of the From Date of Service.** **If included on subsequent K records, must match the zip code on the first K record for the same claim.**	**The U. S. Postal Service five-digit ZIP Code of the Recipient.**
18	**NDC DRUG CODE**	**X(11)**	**11**	**A**	**84**	**94**	**C**	**Include if applicable.** **Must be present if Pharmacy Code (X0263) is present in Record (K) Field 6.** **Must be a valid National Drug Code.**	**National Drug Code for Pharmacy services.**
19	**FILLER (SPACES)**	**X(34)**	**34**	**A**	**95**	**128**	**N**		

RECORD (L): PROVIDER BATCH TRAILER

- Encode one per provider batch.
- Must be preceded by a (K) record.
- Must be followed by a (M) record.

RECORD (L): PROVIDER BATCH TRAILER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
1	RECORD ID 'L'	X(01)	1	A	1	1	R	Must be present. Must be L.	A one-character code that identifies the type of Record.
2	BATCH TOTAL INVOICES (CLAIM HEADER RECORDS)	9(06)	6	N	2	7	R	Must be present. Must equal the number of J Records in this submission file. Must be a valid format as defined in the Field Types section of this document.	A count of the number of invoices (Claim Header Records) contained in the provider batch.
3	BATCH TOTAL CLAIM LINES (CLAIM DETAIL RECORDS)	9(06)	6	N	8	13	R	Must be present. Must equal the number of K Records in this submission file. Must be a valid format as defined in the Field Types section of this document.	A count of the number of service lines (Claim Detail Records) contained in this provider batch.

RECORD (L): PROVIDER BATCH TRAILER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
4	BATCH TOTAL CHARGES	9(08)V99	10	N	14	23	R	Must be present. Must equal the sum of the contents of all Record J Field 19 fields in this submission file. Must be a valid format as defined in the Field Types section of this document.	The total dollar amount billed in this provider file, i.e., a sum of the "Total Usual Fee" fields encoded on the Claim Header Records for this provider's invoices.
5	**UNCOMPENSATED CARE POOL ORGANIZATION ID FOR PROVIDER**	**9(07)**	**7**	**N**	**24**	**30**	**R**	**Must be present.** **Must be valid entry as specified in Code Lists. (Section (1))** **Must match the contents of the preceding Record (H) Field 2.**	**The Organization ID assigned to the provider by the Massachusetts Division of Health Care Finance and Policy.**
6	FILLER (SPACES)	X(98)	98	A	31	128	N		

RECORD (M): TAPE/DISKETTE TRAILER

- Encode one per submission.
- Must be preceded by a (L) record.
- Must be the last record in the file.

RECORD (M): TAPE/DISKETTE TRAILER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
1	RECORD ID 'M'	X(01)	1	A	1	1	R	Must be present. Must be M.	A one-character code that identifies the type of Record.
2	TAPE/DISKETTE TOTAL INVOICES (CLAIM HEADER RECORDS)	9(07)	7	N	2	8	R	Must be present. Must be equal to Record L Field 2. Must be a valid format as defined in the Field Types section of this document.	A count of the number of invoices (Claims Header Records) contained in the entire submission.
3	TAPE/DISKETTE TOTAL CLAIM LINES (CLAIM DETAIL RECORDS)	9(07)	7	N	9	15	R	Must be present. Must be equal to Record L Field 3. Must be a valid format as defined in the Field Types section of this document.	A count of the service lines (Claim Detail Records) contained in the entire submission.
4	TAPE/DISKETTE TOTAL CHARGES	9(09)V99	11	N	16	26	R	Must be present. Must be equal to Record L Field 4. Must be a valid format as defined in the Field Types section of this document.	The total dollar amount billed for all invoices encoded on the entire submission.

RECORD (M): TAPE/DISKETTE TRAILER									
Field No.	**Field Name**	**Picture**	**Byt.**	**Tp.**	**From Pos.**	**To Pos.**	**R?**	**Edits**	**Field Definition**
5	TAPE/DISKETTE TOTAL NUMBER OF PROVIDER BATCHES	9(04)	4	N	27	30	R	Must be present. Must be 1. Must be a valid format as defined in the Field Types section of this document.	A count of the number of unique provider batches encoded on the submission.
6	FILLER (SPACES)	X(98)	98	A	31	128	N		

Code Lists

I) Uncompensated Care Pool Organization ID for Provider

I) Record (H): Provider Batch Header and (L) Batch Trailer: Uncompensated Care Pool Organization ID for Provider			
RT	**Field**	**R?**	**Field Name**
H	**2**	**R**	**Uncompensated Care Pool Organization ID for Provider**
L	**5**	**R**	
Organization ID		**Provider Name**	
15		Boston Health Care for the Homeless	
26		Brockton Neighborhood Health Center	
45		Family Health and Social Service Center	
55		Dimock Community Health Center	
60		Fenway CHC	
61		Geiger Gibson Community Health Center	
63		Great Brook Valley Health Care, Inc.	
64		Greater Lawrence Family Health Center, Inc.	
65		Greater New Bedford Community Health Center	
69		Harvard St. Neighborhood Health Center, Inc.	
72		HealthFirst Family Care Center, Inc.	
74		Hilltown Health Centers	
76		Holyoke Health Center	
80		Joseph M. Smith Community Health Center	
84		Lowell Community Health Center	
86		Lynn Community Health Center, Inc.	

I) Record (H): Provider Batch Header and (L) Batch Trailer: Uncompensated Care Pool Organization ID for Provider			
RT	**Field**	**R?**	**Field Name**
H	**2**	**R**	**Uncompensated Care Pool Organization ID for Provider**
L	**5**	**R**	
Organization ID		**Provider Name**	
87		Manet Community Health Center, Inc.	
90		Mattapan Community Health Center	
102		Neponset Health Center	
108		North End Community Health Center	
111		Outer Cape Health Services, Inc.	
113		Roxbury Comprehensive Comm. Health Cntr. (RoxComp)	
117		Sidney Borum Health Center	
120		South Cove Community Health Center	
121		South End Community Health Center	
125		Springfield South West CHC	
128		Stanley Street Treatment & Resource	
134		Upham's Corner Health Care	
137		Whittier Street Health Center	
1456		North Shore Community Health Center	
1472		O'Neill Health Clinic	

II) Servicing Provider Number

II) Record (J): Claim Detail-1: Servicing Provider Number			
Record	**Field**	**R?**	**Field Name**
J	**5.0**	**R**	**Servicing Provider Number**
Valid Entries			**Definition**
(BORIM #)			Any valid Board of Registration in Medicine number(State License #) as assigned by Board. (Medical Doctor or Psychiatrist)
COUNSE			Counselor
DENT			Dentist
DENTHY			Dental Hygienist
LICSW			L.I.C.S.W.
MIDWIF			Midwife
NURPRA			Nurse Practitioner
OPTOM			Optometrist
PHYAST			Physician Assistant
PODTR			Podiatrist
PSYCH			Psychologist
RNURSE			Registered Nurse

III) Place of Service

III) Record (J): Claim Detail-1: Place of Service			
Record	**Field**	**R?**	**Field Name**
J	**12.0**	**C**	**Place of Service**
Valid Entries: Code			**Definition**
01			Office, facility, or business location
03			Hospital, inpatient
04			Hospital, outpatient
05			Emergency department

IV) Other Insurance Code – Payer Type

IV) Record (J): Claim Detail-1: Other Insurance Code – Payer Type				
Record	**Field**	**R?**	**Field Name**	
J	**16.0**	**C**	**Other Insurance Code – Payer Type**	
Valid Entries: Payer Type Code			**Abbreviation**	**Definition**
1			SP	Self Pay
2			WOR	Worker's Compensation
3			MCR	Medicare
F			MCR-MC	Medicare Managed Care
4			MCD	Medicaid

IV) Record (J): Claim Detail-1: Other Insurance Code – Payer Type				
Record	**Field**	**R?**	**Field Name**	
J	**16.0**	**C**	**Other Insurance Code – Payer Type**	
Valid Entries: Payer Type Code			**Abbreviation**	**Definition**
B			MCD-MC	Medicaid Managed Care
5			GOV	Other Government Payment
6			BCBS	Blue Cross
C			BCBS-MC	Blue Cross Managed Care
7			COM	Commercial Insurance
D			COM-MC	Commercial Managed Care
8			HMO	HMO
0			OTH	Other Non-Managed Care Plans
E			PPO	PPO and Other Managed Care Plans Not Elsewhere Classified
J			POS	Point-of-Service Plan
K			EPO	Exclusive Provider Organization
N			None	None (Valid only for Secondary Payer)

V) Recipient's Sex

V) Record (J) - Claim Detail-1: Recipient's Sex			
RT	**Field**	**R?**	**Field Name**
J	20.0	**R**	Recipient's Sex
Valid Entries			**Definition**
M			Male
F			Female
U			Unknown

VI) Type of Accident

VI) Record (J) - Claim Detail-1: Type of Accident			
RT	**Field**	**R?**	**Field Name**
J	22.0	**C**	Type of Accident
Valid Entries			**Definition**
1			Automobile Related
2			Employment
3			Other

VII) Patient Discharge Status

VII) Record J, Claim Detail-1: Patient Discharge Status			
Record	**Field**	**R?**	**Field Name**
J	26.0	**C**	Patient Discharge Status
Valid Entry		**Patient Discharge Status Definition**	
01		Discharged/transferred to home or self care (routine discharge)	

VII) Record J, Claim Detail-1: Patient Discharge Status			
Record	**Field**	**R?**	**Field Name**
J	26.0	**C**	Patient Discharge Status
Valid Entry		**Patient Discharge Status Definition**	
02		Discharged/transferred to another short-term general hospital	
03		Discharged, transferred to Skilled Nursing Facility (SNF)	
04		Discharged/transferred to an Intermediate Care Facility (ICF)	
05		Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution	
06		Discharged/transferred to home under care of organized home health service organization	
07		Left against medical advice	
08		Discharged/transferred to home under care of a Home IV Drug Therapy Provider	
10		Discharged/transferred to chronic hospital	
11		Discharged/transferred to mental health hospital	
12		Discharge Other	
13		Discharge/transfer to rehab hospital	
14		Discharge/transfer to rest home	
15		Discharge to Shelter	
20		Expired (or did not recover – Christian Science Patient)	
31		Still an Inpatient	
50		Discharged to Hospice – Home	
51		Discharged to Hospice Medical Facility	

VIII) Original, Resubmittal, Late Charges, Void Indicator

VIII) Record (J): Claim Detail - 1: Original, Resubmittal, Late Charges, Void Indicator			
Record	**Field**	**R?**	**Field Name**
J	**29.0**	**R**	**Org, Resub, Late Charges, Void Indicator**

Valid Entries:	Type	Definition
O	Original	This code is used for a bill encompassing an entire course of treatment for which the provider expects payment from the payer. **Charges claims must have a unique TCN.**
R	Replacement of a Prior Claim	This code is used by the provider to resubmit a previously submitted bill. This is the code applied to the corrected bill. **The resubmitted claim must have the same TCN as the original claim.** **The resubmitted claim must have the same UC Write Off Date (Record (K) Field 16) as the original claim.** **Use replacement claims for previously submitted claims which fail edits.** **Do not use replacement claims to resubmit previously accepted claims if the charges are being adjusted.** **Do NOT use a replacement claim in combination with a void claim when correcting a bill.**
L	Late Charges Only	Use this code to indicate this bill is for late charges to be applied to a previously submitted bill. **Late Charges claims must have a unique TCN.**
V	Void/Cancel of a Prior Claim	Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. **The voided claim must have the same TCN as the original claim. The UC Write Off Date must be the month and year the recovery is made and reported on the PV form (Record (K) fields 15 and 16).** **A void claim may be used in combination with a new claim in order to correct charges.**

IX) Procedure Code (Service Code)

IX) Record K, Claim Detail-2: Procedure Code			
Record	**Field**	**R?**	**Field Name**
K	6	**R**	Procedure Code
Valid Entry: Service Code:			**Procedure (Service) Code Definition**
Refer to DMA Manual with the exception of invalid "X" Codes			Must be a valid DMA service code as found in subchapter 6 of the relevant DMA community health center provider manual with the exception of the following service codes which are **NOT** valid. X5902 (individual medical visit) X5903 (individual mental health visit)
Replace invalid DMA "X" codes with:			**Service Description**
X0256			Office visit with a **Medical Doctor**
X0257			Office visit with a **Nurse Practitioner**
X0258			Office visit with a **Physician's Assistant**
X0259			Office visit with a **Nurse Midwife**
X0260			Office visit with a **Psychiatrist**
X0261			Office visit with a **Psychologist**
X0262			Office visit with a **L.I.C.S.W.**
Additional DHCFP Codes:			**Service Description**
X0263			Use Code **X0263** for every **Pharmacy** service provided. **Corresponding NDCs (National Drug Codes) must be present in Record (K) Field 18 every time the pharmacy service code is listed.**
X0264			**Patient Co-pay or Deductible**
X0265			Office visit with a **Nurse**
NOTE: For **Dental services**, indicate all dental service/procedure codes provided, and usual fees on the Claim Detail-2 ***Record (K) Field 13 Usual Fee***.			

X) Procedure Code Modifier

X) Record K, Claim Detail-2: Procedure Code Modifier			
Record	**Field**	**R?**	**Field Name**
K	7	**C**	Procedure Code Mod.
Valid Entry:			**Procedure Code Modifier Definition**
DS			Child in DSS custody: first 72 hours: initial visit
TC			Technical component
X2			CHC- EPSDT visit
YS			Outpatient office visit
YX			Eye exam without cycloplegic or mydratic drop
YZ			Additional patient seen in nursing home
21			MMPCS modifier
22			Unusual services
24			MMPCS modifier
26			Professional component
42			MMPCS modifier
50			Bilateral procedures
51			Multiple procedures
54			Surgical care only
80			Assistant surgeon
99			Multiple modifiers

File Submission Rules

Submissions must be done at least monthly. Twice a month or weekly submissions are allowed.

File Format

Text file containing 128-character rows.

Data Transmission Media Specifications

The Division's goal is to collect claims data via a Virtual Private Network (VPN). However, at this time the state is just beginning the implementation of its VPN network and is not yet prepared to offer it as a data transmission option. As an interim measure, the Division will collect the information on any one of the media types described below.

Multi-volume not allowed.

Diskette:

A 3 _ inch IBM format diskette, double sided, high density, 1.44 MB.

Compact Disk:

A Compact Disk (CD) with a total capacity of 650 megabytes is the standard format accepted. CD-R and CD-RW are also acceptable formats as long as the CDs themselves have been closed (no more data can be added to them).

Zip Disk:

An Iomega Zip Disk with a total capacity of either 100 megabytes or 250 megabytes is the standard format accepted. The Division is equipped to handle either of these Zip Disk formats.

DAT Tape:

A 4mm (Digital Audio Tape) cartridge with a total capacity of 4.0 gigabytes is the standard format accepted.

DLT Tape:

A _" (Digital Linear Tape) cartridge with a total capacity of 35 gigabytes (uncompressed) and 70 gigabytes (compressed) is the standard format accepted.

Software Supported

- Veritas – Backup Exec 8.0
- Microsoft – NT Backup 4.0
- Iomega – 1 Step Backup/Restore

Diskette/CD/Tape Label Information:

Each submission must be clearly labeled with the following information:

Division of Health Care Finance and Policy
Uncompensated Care Pool CHC Claims Data
Provider Name
Provider Organization ID
Date of Submission

Submission Acceptance Rules

Files will undergo a series of record checks or edits at the record and field level. The data will be edited for compliance with the edit specifications set forth in this document. Failure of these edits will cause a File or a Claim to fail. Any of these items, if failed, must be resubmitted in full.

File Level Edits

Files with any missing or failed records of Record Types G, H, L, or M must be resubmitted in full.

Record Level Edits

Records with incorrect format, or with any fields that fail edits, will be considered failed records. Certain errors will not cause a record to fail, but will be reported in the remittance advice.

Records must have the following format:

- 128 character row.

Claim Level Edits

All errors will be recorded for each claim. A claim will be rejected from the data file for any failed fields/records. Claims with any failed data in Record Types J or K must be resubmitted in full.

Electronic Claims File Summary Report

An Electronic Claims File Summary Report will be returned to Providers, outlining file summary information and individual claim edit information.

Submission Cover Sheet

Each submission file must be accompanied by a Transmittal sheet. A diskette submitted with several files on the diskette must have a separate transmittal sheet for each file. The following information must be included:

UCP CHC CLAIMS

Division of Health Care Finance and Policy
Uncompensated Care Pool CHC Claims Submission Transmittal Sheet

Community Health Center Name: _____
Submitter Name: (if different from CHC) _____
UCP Organization ID: _____
File Name: _____
Submission Date: _____

Total number of claims in batch: _____

Total visit charges for all claims in batch: _____

Total ancillary charges for all claims in batch _____

Batching information: **only complete this section if write-off dates are not being indicated on individual claims**
If claims are batched by write-off date, indicate batch month and year: MONTH:_____YEAR:_____
YOU MAY ONLY BATCH FILES BY A SINGLE MONTH AND YEAR, NOT MULTIPE MONTHS AND YEARS

Note each submission can only have ONE batch month and year, not a range

Contact at the provider site to receive edit report….please provide an email address:

Contact Name: _____
Facility: _____
Phone: _____
Email: _____

Label disks or tapes with the following information:
Provider Name
Organization ID
Submission Date
"Uncompensated Care Pool CHC Claims Data"

Mail claims submission to:
Division of Health Care Finance and Policy
2 Boylston Street
Boston, Massachusetts 02116-4704
Attn: UCP claims-ITG

Please indicate UCP CHC Claims on your tape or disk label

If you have questions contact the claims help desk at 1-800-542-7648 or your provider liaison